Meeting Notes
Quality Metrics Subcommittee Meeting
October 26, 2011

Members present: **Paula Block**, CHC-Montana Primary Care Association; **Dr. Doug Carr**, Billings Clinic; **Dr. Janice Gomersall**, Montana Academy of Family Physicians; **Dr. Jonathan Griffin**, St. Peter's Medical Group; **Marie Hamilton,** Bozeman Deaconess; **Janice Mackenson,** Mountain Pacific Quality Health; **Dr. Fred Olson**, BCBS MT; **Dr. Bob Shepard**, New West Health Services; **Dr. Rob Stenger**, Grant Creek Family Practice, St. Patrick's Hospital;

Interested Parties present: **Dr. Jay Larson**, Independent Provider**;** Will Robinson, National Committee on Quality Assurance (NCQA); Myrna Seno, Mountain Pacific Quality Health; Nancy Wikle, DPHHS Medicaid, Care Management Supervisor; **Claudia Stephens**, Montana Migrant and Seasonal Farm Worker Council; **Kristin Juliar**, Montana Office of Rural Health; **Dr. Tom Roberts**, Western Montana Clinic; **Dr. Paul Cook**, Rocky Mountain Health Network; **Kristina Davis,** Children's Defense Fund;

CSI Staff present: Christine Kaufmann

The meeting was called to order by Chair, Bob Shepard at 1:05 pm. Notes from the previous meeting on September 28 were presented for review. The October 12 meeting announced in the notes did not occur.

A1. Drop down list of communication preferences from Bozeman Deaconess' system was postponed for the next meeting

A2. There was discussion on ways of measuring access. Providers described systems that were highly variable, just being implemented, not standardized within a practice system, or were not being used. Other providers were encouraged to learn what their systems can do. No decision was reached.

A3. NCQA and US Preventive Service Guidelines for Osteoporosis were discussed. There are two approaches. One is a treatment measure for those who have had fractures. The other is a general screening for women over 65.

Decision: The Subcommittee agreed both measures should be used. PCMH is about prevention, not just treatment.

A4. The research on Mental Health needs to be done. The subcommittee raised issues for a later discussion with mental health professionals. Should the mental health facility be the medical home? Should children and adults be considered separately? One member noted that NCQA has measures, but they are not easy to use with this diagnosis. Another noted that one model calls for a medical provider to be co-located at a mental health clinic, but does not include specific mental health quality measures.

A5. The Subcommittee discussed the need to use a standard survey to measure patient satisfaction. Participants were reminded to listen in to the CAHPS/NCQA free webcast on Thursday, November 3rd at

noon. They will be highlighting their survey for measuring patient experiences with medical homes. The link was sent out by Dr. Carr -- http://event.on24.com/r.htm?e=355650&s=1&k=C4179450E3F4D60B8AB5C7DA5E912540&partnerref=gvdel. The CAHPS survey will be validated and will allow us to compare to national standards. It is specific for medical homes. There is a cost, however. The group discussed the need for web-based surveys and the potential bias favoring those who use the web compared to the response rate. The group hopes to decide what survey they will accept after the webcast. Will Robinson of NCQA was on the call and said the survey was just being rolled out and he would be willing to have someone from NQCA on the line next call to answer any questions after the webcast.

B6. The group agreed there would be value in putting together attributes for data system to be used in a medical home program in Montana. The following items were discussed:

a. The system would need the capacity to capture all 190 quality measures recommended by NCQA.
b. The system would need to be able to capture any additional measures Montana may want to recommend.
c. They system would need flexibility to capture new data elements as the need arises. For example it needs to be prepared for stage 2 Meaningful Use. It must stay ahead of the curve and provide a roadmap for the future.
d. The system would need to respond to the details of various initiatives as they come out from CMS such as Meaningful Use and Care Transitions. CMS will need to see the annual wellness visit and a field for medication reconciliation. That may include different type of reconciliation--information on conflicting medications, patient understanding, prescriptions of various providers, and information on whether patients are filling and refilling their prescriptions. Current EMRs have a field for medication reconciliation, but not a way to document the type of reconciliation. Patient reporting is not very reliable. Payers can document claims data, but that doesn't cover over the counter meds or Walmart's program. Sure Scripts gives information on other providers. Venders say they can do whatever is asked. The question is can the providers capture the information to put in.
e. The system needs to be easy to implement and use by everyone who need to use it.
f. The system should have information exchange capabilities, be able to plug into a larger network, to capture meaningful use, and the share information across the medical neighborhood. All this will be required by CMS in the future.
g. A system needs the be capable of hosting a 24/7 patient portal, conversations between specialists, a risk-stratified Care Management system and other functions outlined in the CMS Comprehensive Primary Care Initiative.
h. The Advisory Council should make sure our consideration of data system attributes are available at the BCBS meeting even though we are not making a recommendation on a specific vender.

C.

- The group discussed the upcoming meeting hosted by BCBS to get feedback on a data repository. It will consist of a series of webinars scheduled in the coming two weeks and be moderated by Rick Yearry. All primary care sites across the state will be invited—186 sites consisting of 590 providers. The group clarified that CHCs are on the list.
- The group identified next steps for the subcommittee-- finalizing data set and quality measures, including mental health measurers, patient satisfaction survey, appointment scheduling measures and benchmarks for all measures
- CMS Proposal:
    - Nancy Wilke of DPHHS Medicaid will be sitting in for John Hoffland in upcoming meetings due to workload issues at DPHHS. She has drafted a letter for Medicaid participation with the CMS Comprehensive Primary Care Initiative and is waiting to hear the administration's decision. The letter was coordinated to fit in with the efforts of other payers.
    - If Montana's proposal is selected, CMS will work with all parties to facilitate a process and avoid anti-trust issues. Pricing information and market share will be submitted separately and CMS will add it up on their end.
    - There was interest in whether the state plan could submit. The group decided the TPAs would submit on behalf of the plan, which would then be involved if Montana is selected to submit a full proposal.
    - The group noted the CMS wants a large number of covered lives and a state-wide market. Lines of business will not be specified until the final application.
    - Payers are accepting the responsibility of making this happen for the provider communities. Providers will not be applying. The cost will be reimbursed by the shared savings down the road.